New CMS model focuses on social determinants of health measures

A bit over a decade ago, my son Tripp Logan and I penned an article for *America's Pharmacist*® magazine entitled, "Your future is in the stars." That article contained information about the Centers for Medicare and Medicaid Services' (CMS) new (at that time) Star Ratings program for Medicare Advantage and Part D plans. In that article we talked about the effect the CMS Star Ratings would have on the plans, how much potential money was involved and how pharmacists fit into the picture.

We noted that plans would be dependent upon pharmacist involvement to raise their Star Ratings and put them in line for what CMS termed "bonus payments." A significant portion of those payments were based on things such as medication adherence, appropriate use of medications in diabetes, and use of statins, to name several. All of these things walked through the doors of community pharmacy and were things we, as community pharmacists, were able to affect. Based partly on the hard work of pharmacists, plans did, in fact, receive bonus payments for those Star Ratings measures. In some cases those bonus payments stretched into the billions of dollars.

FOCUSING ON HEALTH EQUITY

CMS had high hopes that this Star Rating system and the accompanying bonus payments would lead to improved patient care, quality patient outcomes and lower health care costs. It did not turn out quite as anticipated. Health care costs continued to rise, and quality did not greatly improve. CMS went back to the drawing board. The drawing board in this case was the CMS Innovation Center. If you are not familiar with the CMS Innovation Center, it's the "let's try this and see if it works" laboratory that CMS uses to test new ideas. As CMS describes it, the CMS Innovation Center "develops and tests new health care payment and service delivery models to improve patient care, lower costs and better align payment systems to promote patient-centered practices." This is the part of CMS that explores alternative payment models that promote and encourage value-based payment models.

In 2021, the CMS Innovation Center began prioritizing health equity in all of its operations. Why, you ask, is health equity important? First, let's define health equity. According to the Robert Woods Johnson Foundation, "Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness, and lack of access to good jobs with fair pay, quality education and housing, safe environments, and healthcare."

To this I would add things such as food security and a strong social support system. All of these things fall into the realm of social determinants of health (SDoH) issues. If you think about it, someone who does not know where their next meal is coming from is not going to be worried about their blood pressure until they have a stroke or heart attack. Caring for a stroke patient costs the health care system much more than the sack full of groceries it would have taken to provide food security for that person. Health inequity, fueled by SDoH issues, is expensive. In fact, Deloitte Consulting has concluded that health inequities account for $320 billion (yes, with a b) in annual health care spending. Deloitte also concluded that, if unaddressed, that number could grow to $1 trillion (yes, with a t) by 2040. Hence, CMS interest in SDoH and health equity.

The stars realign around health equity

by Richard Logan, Jr., PharmD

HEALTH EQUITY INDEX

To address this $320 billion to potentially $1 trillion dollar, largely unnecessary, expense, CMS announced that 2027 will herald the year in which the current reward factor in the CMS Star Ratings bonus payment formula will be replaced with something called the Health Equity Index (HEI). The HEI is not a risk adjustment of a current measure (micro-analysis), but a plan level (macro) analysis that can lead to a plus or minus 40 percent adjustment to a plan's bonus payment.

Wait, what is that? Do I hear plans and PBMs shrieking with delight over this change? Is that delight or is that just shrieking? A change, and a big change, is coming to their longtime business operations. In Cameron Mackintosh's wonderful musical adaptation of "Les Miserables," Javert, the misguided gendarme and antagonist, vocalizes in the song "Stars" that "stars know their place in the sky, hold their course and their aim and are always the same." Javert's stars are constant and unchanging. CMS Star Ratings? Not so much. They are changing. In what amounts to a seismic shift to health equity, the CMS Star Ratings bonus structure will move to promoting a more holistic approach to patient care by focusing on SDoH and access to care issues.

The billions of dollars available to plans for bonus payments will soon be based on a fairly complex formula surrounding the health equity of their clients. This complicated formula involves leveraging patient SDoH issues, multiplier decimals, and negative or positive numbers, to arrive at a final multiplier decimal to be applied to the possible bonus pool of money available to a plan and (finally) arrive at a bonus amount (or not if negative). Broken down, it is basically, "Dear healthcare plan, have you identified your clients with social issues that keep them from achieving health equity and what have you done to alleviate it?" The plans that do well stand to receive some of the billions of dollars in bonus payments available, while the plans that don't do well stand to lose access to that money. As mentioned before, there is the possibility of up to 40 percent more or 40 percent less for bonus amounts. In dollar amounts that start with a "b" they become very significant very quickly.

CREATING A FRAMEWORK

From a health plan perspective, it is imperative that each have the ability to identify their clients with health equity issues, develop a formula to address those issues and be able to effectively report those things back to CMS. While the bonus structure change will not lead to actual bonus dollars until 2027, it will be based on measurements and data collected beginning in 2024. Beginning Jan. 1, 2024, plans will need to have the ability to create a framework of SDoH screening tools for patient assessment and a program to address the issues found on a local level, and have the capability to report that back to CMS.

The key phrase here is on a local level. Plans will need to do outreach, assessment, and resolution in neighborhoods throughout the country. Many of the patients who are most in need of this outreach and resolution are the sickest of the sick, the neediest of the needy, the hardest to reach, and the most untrusting of big corporations. How will plans be able to affect this population in a meaningful way from corporate offices, telephone banks, and computer screens with fill-in-the-blank surveys?

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> ***"By virtue of our locations, accessibility, longitudinal patient relationships and familiarity with local services, community pharmacies are uniquely positioned to identify, intervene and respond to individuals in need."***

The answer clearly is, they can't. Not without help. If this endeavor is to be successful and effective with positive health outcomes, it will need trusted faces with boots on the ground, in the neighborhoods where people live and who are familiar with local resources and solutions. Plans will need community pharmacy.

Community pharmacies nationwide currently serve high-risk populations, many in need of SDoH services to improve health equity. We are on the front lines of the health inequity crisis. By virtue of our locations, accessibility, longitudinal patient relationships and familiarity with local services, community pharmacies are uniquely positioned to identify, intervene and respond to individuals in need. To do that, however, pharmacy must prepare. No longer is the model "fill more prescriptions faster" viable. We must branch out into services that bring in non-traditional revenue and improve patient care. Working with the health care plan to identify, rectify and report on SDoH issues will be one of those services.

GETTING IN THE GAME

As health plans ready themselves for 2027 and begin collecting data in 2024, how can community pharmacy ready itself to be a participant in the process? The Community Pharmacy Enhanced Services Network-Health Equity (CPESN-HE), a specialty network of CPESN® USA, has been working to ready pharmacies to address the health inequity crisis. CPESN-HE advocates cross training pharmacy technicians as SDoH specialists and community health workers (CHW) and embedding them into the practice of pharmacy. (See cpesn.com/index.php/health-equity for more information.)

If you are not familiar with the terms, an SDoH specialist is a pharmacy technician who has had training to become familiar with social issues that affect health inequity, and a community health worker in the pharmacy is a technician who has completed a certification course and become a certified CHW. For context, the definition of CHW, as recognized by organizations such as the American Public Health Association and the Centers for Disease Control and Prevention, is as follows.

A community health worker is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.

As you read the definition of a CHW it is easy to draw a parallel to the work of pharmacy technicians. Words like "trusted member of the community" and "trusting relationships" resonate in the pharmacy world. The qualifications for a pharmacy technician and a CHW, both personal and professional, intersect at multiple locations. In fact, the last few years have seen many pharmacy technicians cross trained as CHWs.

SDoH specialists and CHWs in the pharmacy are well suited to the

tasks of not only identifying and addressing health inequities, but of closing gaps in care. Coupled with their close working relationship with a highly trained pharmacist and unparalleled patient access, CHWs in the pharmacy can and are able to assist in addressing both clinical and social issues affecting patient care. Whether doing educational outreach in neighborhoods that are at high risk for poor health outcomes, working on chronic care management with high-risk patients, or helping with vaccine hesitancy and closing vaccine gaps, CPESN-HE trained CHWs are creating positive outcomes for patients and improving health equity.

ECONOMIC BENEFITS

There is also an economic argument to be made for modifying pharmacy practice and addressing health equity with pharmacy CHWs. As plans begin gathering information for the HEI bonus transition in 2024, CHWs have both the ability and the patient access to gather and understand that information. As SDoH issues are identified, pharmacy CHWs have knowledge of local referral networks for resolution of those issues. Payers and plans will need to have that information and the resolution of the issue readily available and reportable to CMS. If pharmacy is ready, there will be opportunities to both increase revenue and provide valuable services that no one else can match.

Beyond the plan level and health equity index, CHWs in the pharmacy can open up grant opportunities and other collaborative efforts that have the potential to bring in additional revenue. While there are national efforts surrounding the HEI, possible state and local opportunities abound. Whether it's participating in a grant for a self-measured blood pressure program, or addressing vaccine hesitancy, payment models exist that thrust pharmacists directly in the middle of the value-based care payment model (VBC) to provide quality care and improve patient outcomes.

NOT A FEE FOR SERVICE MODEL

The VBC model is not a fee-for-service (FFS) model. To enter the world of VBC is going to require a change or at least a tweak in our FFS practice model. Along with regular dispensing, we will have to add services which patients require, payers need and for which they are willing to pay. It will require work and it will take time and effort to develop. A single pharmacy with an SDoH specialist or CHW may contract with a local entity to participate in a grant or provide services for a fee. If we are looking at a regional, state, or national effort, that effort will best be done by a network of pharmacies focused on health equity. CPESN-HE is such a network. CPESN-Health Equity provides the framework for pharmacies entering into a health equity focused practice.

There is really no constant but change. Even if no one wishes for change, it is inevitable. To quote author Malcolm Gladwell, we are at a "tipping point." Pharmacy can either guide the change or be crushed by it. With the devolution of pricing and profitability in the dispensing model, added services and the revenues they generate will be key, not only to independent practice survival, but the evolution of independent practice into a robust, sustainable, profitable, health care service. Focus within the pharmacy on patient care and health equity is the first step. ■

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For information on source material used in this article, please contact Chris Linville, America's Pharmacist® *managing editor, at chris.linville@ncpa.org.*